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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jan/27/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: RT knee scope partial medial meniscectomy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Orthopedic Surgery

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is the opinion of this reviewer that the request for RT knee scope/partial medial meniscectomy is not medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: This patient is a female. On 10/06/14, plain x-rays revealed small osteoarthritic spurs in the distal right femur. On 10/31/14, an MRI of the right knee revealed the medial meniscus had a radial tear of the body section and the lateral meniscus had tearing of the anterior surface of the posterior horn. The major ligaments were intact. Tricompartmental osteoarthritis was noted with a lateral tilt to the patella and moderate joint effusion. On 11/24/14, the patient was seen in clinic and was able to flex actively 100 degrees and extension was full. She had a positive McMurray's and a negative Lachman's test. She was stable to varus and valgus stress testing. Both conservative non-operative care was discussed as well as operative care and she would like to proceed with surgery.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: On 12/11/14, a notice of adverse determination was submitted for the requested right knee arthroscopy and partial medial meniscectomy. It was noted that there were no imaging findings to suggest a tear of the meniscus, and conservative treatment had not been documented. Subjective clinical findings of pain and limitation of activities despite conservative treatment had not been documented. The requested service was deemed not medically necessary at that time. On 12/29/14, an adverse determination notice was submitted for the requested right knee arthroscopy and partial medial meniscectomy, and there is no imaging evidence documented to confirm the presence of a meniscal tear, and evidence of a recent, reasonable, and/or comprehensive non-operative treatment protocol trial and failure had not been submitted. The request was non-certified. The additional records submitted for this review do contain the imaging study which reveals that this patient has a medial meniscus with a radial tear of the body section and a lateral meniscus tear of the anterior surface posterior horn. Guidelines indicate the surgery may be considered reasonable if there is documentation of conservative care although conservative care is not recommended or required for locked and/or blocked knee.

While it was noted this patient has a positive McMurray's on physical examination, and she has findings of an MRI verifying tears of the medial and lateral menisci, there is a lack of documentation of significant current conservative care such as physical therapy. Therefore, it is the opinion of this reviewer that the request for RT knee scope/partial medial meniscectomy is not medically necessary and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)